PRINTED: 05/17/2012

CENTERS FOR	ON	MB NO. 0938-0391					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/18/2012	
	PROVIDER OR SUPPLIEF SITY PARK HEALT	R H AND REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825				
(X4) ID PREFIX TAG K0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
NOOOU	and State Licer conducted by to Department of accordance with Survey Date: Of Facility Number Provider Number AIM Number: Surveyor: Amy Code Specialist At this Life Safe University Park Rehabilitation on the compliant Requirements of Medicare/Medicare/Medicare/Medicare/Medicare Association (Nither National Fither National Fither National Fither Association (Nither Code (LSC), Chinarcondense Association (Nither Code (LSC))	th 42 CFR 483.70(a). 24/18/12 r: 000459 ver: 155567 100289700 v Kelley, Life Safety t ety Code survey, thealth and Center was found nce with for Participation in icaid, 42 CFR O(a), Life Safety the 2000 edition of	K000	00	The creation and submission of the plan of correction does not constitute an admission by this provider of any conclusion set for in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 05/18/2012.	ch r s e	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

determined to be of Type V (111)

This one story facility was

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155567	(X2) MULTIPLE CONST A. BUILDING B. WING	01	COMPLETED 04/18/2012
	PROVIDER OR SUPPLIER SITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDI	RESS, CITY, STATE, ZIP CODE ICAL PARK DR YNE, IN 46825	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 104 and had a census of 82 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/24/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI21

Facility ID: 000459

If continuation sheet

Page 2 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	
		155567	B. WIN	G		04/18/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SITY PARK HEALTI	H AND REHABILITATION CENTER	₹		EDICAL PARK DR VAYNE, IN 46825		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0025 SS=D	NFPA 101 LIFE SAFETY C Smoke barriers a least a one half h accordance with terminate at an a protected by fire- glass panels and two separate cor each floor. Damp penetrations of s heating, ventilati systems. 19.3 19.1.6.4 Based on obser interview, the f ensure 1 of 1 c barriers was ma a one half hour rating. LSC 8.3 barriers shall b an outside wall This deficient p the 2 residents 315 on the Mer Findings include Based on an ob- Maintenance St 04/18/12 at 1:	ODE STANDARD are constructed to provide at mour fire resistance rating in 8.3. Smoke barriers may atrium wall. Windows are rated glazing or by wired a steel frames. A minimum of mpartments are provided on pers are not required in duct smoke barriers in fully ducted ing, and air conditioning 8.7.3, 19.3.7.5, 19.1.6.3, and air conditioning smoke aintained to provide a fire resistance 8.2 requires smoke be continuous from to an outside wall. Oractice could affect in resident room mory Care hall.	K00		K 025 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of this provider to ensure smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. The two residents that reside in resident room 315 were not affected by this alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The identified one and one half inch hole in the ceiling at the side of the	e S	DATE 05/18/2012
	one and one ha	alf inch hole in the			, ,		
	ceiling at the s	ide of the sprinkler			•		
	_	acknowledged by			place or what systemic changes wil	I	
		ce Supervisor at the			be made to ensure that the		
	closet in reside one and one ha ceiling at the si head. This was	ent room 315 has a alf inch hole in the ide of the sprinkler s acknowledged by			sprinkler head was filled by the facility Maintenance Director. What measures will be put into place or what systemic changes wil	ı	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI21

Facility ID: 000459

If continuation sheet

Page 3 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
		155567	B. WING 04/18/2012				
NAME OF P	DOMDED OF CLIPPLIES		STREET .	ADDRESS, CITY, STATE, ZIP CODE	•		
NAME OF P	PROVIDER OR SUPPLIER		1400 M	IEDICAL PARK DR			
		H AND REHABILITATION CENTER	R FORT	WAYNE, IN 46825			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	time of observa	ation.		deficient practice does not recur:			
				A facility audit was conducted by th			
	3.1-19(b)			Maintenance Director to ensure the	2		
	3.1 13(5)			smoke barriers were compliant with	1		
				this alleged deficient practice			
				throughout the facility.			
				How will the corrective action(s) be			
				monitored to ensure the deficient			
				practice will not recur i.e., what			
				quality assurance program will be			
				put into place: The Proventive Maintenance system	,		
				The Preventive Maintenance systen TELs was updated to include			
				resident rooms, storage rooms, and			
				office space to inspect smoke			
				barriers to ensure ongoing			
				compliance. Findings will be			
				reported to the Executive Director			
				for review and follow up. The			
				Maintenance Director will complete			
				weekly inspections x 3 months and			
				then monthly x 3 months or until			
				substantial compliance.			
				By what date the systemic change	s		
				will be completed: Compliance Date	e		
				= 05/18/2012			
1	i		1	i e	l l		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI21

Facility ID: 000459

If continuation sheet

Page 4 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155567	B. WING			04/18/	2012
			D. W.L.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EDICAL PARK DR		
UNIVERS	SITY PARK HEALTI	H AND REHABILITATION CENTER	₹		VAYNE, IN 46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0056	NFPA 101						
SS=D		ODE STANDARD					
		omatic sprinkler system, it is					
		dance with NFPA 13, Installation of Sprinkler					
		ride complete coverage for all					
		uilding. The system is					
		ned in accordance with NFPA					
		the Inspection, Testing, and					
		Water-Based Fire Protection					
		lly supervised. There is a					
		e water supply for the ed sprinkler systems are					
		ater flow and tamper					
		are electrically connected to					
	the building fire a	•					
	Based on obser	vation and	K00	56	К 056		05/18/2012
	interview, the f	acility failed to			What corrective action(s) will be		
	ensure 3 of 5 s	prinkler heads in			accomplished for those residents found to have been affected by the		
	the employee le	ounge were			deficient practice:		
	separated by at	t least six feet as			It is the practice of this provider to		
	required by NF	PA 13. NFPA 13			ensure the automatic sprinkler		
	Section 5-6.3.4	1 requires			system is installed in accordance		
	sprinklers be lo	ocated no closer			with NFPA 13, the standard for the	4	
	than six feet m	easured on center.			installation of Sprinkler Systems, and to provide complete coverage for al		
	This deficient p	oractice could affect			portions of the building.		
	any number of	staff in the			How other residents having the		
	=	ge in the event of a			potential to be affected by the		
	fire emergency	_			same deficient practice will be		
	c cc.gc.icy	-			identified and what corrective		
	Eindings includ	lo:			action(s) will be taken:		
	Findings includ	IC.			No residents or employees were		
					identified to be affected by this		
	Based on obser				alleged deficient practice. What measures will be put into		
	Maintenance Su	upervisor on			place or what systemic changes wil	I	
	04/18/12 at 1:	55 p.m., three of			be made to ensure that the	-	
	the five sprinkl	er heads in the			deficient practice does not recur:		
	-				•		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI21

Facility ID: 000459

If continuation sheet

Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155567	B. WIN	G		04/18/	2012
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C	1400 MEDICAL PARK DR				
UNIVERS	SITY PARK HEALT	H AND REHABILITATION CENTE	R	FORT V	VAYNE, IN 46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	employee loun	ge were mounted			All residents or employee have the		
	near the emplo	oyee lounge			potential to be affected by this		
	entrance door.	The center			alleged deficient practice. The		
	sprinkler head	was located four			identified sprinkler head was		
	_ ·	prinkler head to the			removed from the employee break room. Maintenance Director		
	right and four				conducted a facility audit of the		
	•				Sprinkler Heads throughout the		
	sprinkler head				facility to ensure all sprinkler heads		
		were provided by			are no closer than 6 feet apart.		
	the Maintenand	ce Supervisor. This			How will the corrective action(s) be		
	was acknowled	lged by the			monitored to ensure the deficient		
	Maintenance Si	upervisor at the			practice will not recur i.e., what		
	time of observa	•			quality assurance program will be		
					put into place:		
	3.1-19(b)				The Maintenance Director		
	3.1-19(b)				completed a facility audit of all		
					sprinkler heads to ensure facility		
					wide compliance. Findings were		
					reported to the Executive Director for follow and review.		
					By what date the systemic changes		
					will be completed: Compliance Date		
					= 05/18/2012	•	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI21

Facility ID: 000459

If continuation sheet Page 6 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	01	COMPL	ETED
		155567	A. BUIL B. WING			04/18/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			EDICAL PARK DR		
UNIVERS	SITY PARK HEALTH	H AND REHABILITATION CENTER	₹		VAYNE, IN 46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0074 SS=B	Draperies, curtain curtains, and oth and films serving decorations in he accordance with NFPA 13, Standa Sprinkler System accordance with Newly introduced health care occurs specified when the methods cited in 19.7.5.1, NFPA Newly introduced Newly Newly Newly introduced Newly N	d upholstered furniture within pancies meets the criteria ested in accordance with the 10.3.2 (2) and 10.3.3.					
	19.7.5.3 Based on obser	vation and	K00	74	К 074		05/18/2012
	interview, the f	acility failed to			What corrective action(s) will be		
	ensure window	curtains at 6 of 6			accomplished for those residents found to have been affected by the		
	windows in the	Memory Care			deficient practice:		
		ere flame retardant.			It is the practice of this provider to		
	_	oractice could affect			ensure draperies, curtains, including	5	
	•	esidents in Memory			cubicle curtains, and other loosely		
	Care.				hanging fabrics and films serving as		
	carc.				furnishings or decorations in		
	Findings includ	lo:			healthcare occupancies are in		
	Findings includ	ie.			accordance with provisions of 10.3.1	L	
	D 1 '				and NFPA 13, Standards for the Installation of Sprinkler Systems. The	۵	
		rvations with the			twenty residents identified on the	_	
	Maintenance Su	·			facility Memory Care Unit had the		
	04/18/12 at 1:	•			potential to be affected by this		
	window curtain	is in the Memory			alleged deficient practice.		
	Care dining roo	om lacked attached			How other residents having the		
					potential to be affected by the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI21 Facility ID: 000459

If continuation sheet Page 7 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155567	B. WING		04/18/2012
	n oxympun o	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L .	1400	MEDICAL PARK DR	
UNIVERS	SITY PARK HEALT	H AND REHABILITATION CENTE		WAYNE, IN 46825	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	documentation	confirming they		same deficient practice will be	
	were inherently	/ flame retardant.		identified and what corrective	
	Based on interv			action(s) will be taken:	
		upervisor at 2:40		All residents have the potential to b	oe e
		•		affected by this alleged deficient	
		/12, there was no		practice. The Maintenance Director	•
		regarding flame		treated the 6 identified curtains in	
	retardancy for	these window		the Memory Care Unit with a fire	
	curtains availal	ole for review.		retardant spray. What measures will be put into	
				place or what systemic changes wi	u l
	3.1-19(b)			be made to ensure that the	"
				deficient practice does not recur:	
				The Maintenance Director	
				completed a facility audit all of	
				window treatments to ensure all	
				curtains have the proper fire spread	. l
				identified on them. The curtains that	
				did not have an identified fire	
				spread rating were treated with a	
				Fire Retardant spray. All curtains w	ill
				be marked by the Maintenance	
				Director to indicated the material	
				was treated with the fire retardant	
				spray or have a lable from the	
				manufactor indicating the proper	
				fire spread rating.	
				How will the corrective action(s) b	e
				monitored to ensure the deficient	
				practice will not recur i.e., what	
				quality assurance program will be	
				put into place: The Maintenance Director will keep	,
				a tracking log with all identified	, l
				curtains to ensure the material has	
				been treated with the fire retardan	
				spray or meets the proper fire	
				spread rating. The Maintenance	
				Director in-serviced facility staff to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI21

Facility ID: 000459

If continuation sheet

Page 8 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/18/2012
UNIVERS		H AND REHABILITATION CENTE	1400 M FORT V	ADDRESS, CITY, STATE, ZIP CODE IEDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE COMPLETION DATE
				ensure new material is treated w the spray or has a label identifyin the proper fire spread rating. The facility Preventive Maintenance program was updated to ensure routine inspections of the window treatments to ensure ongoing compliance. By what date the systemic chan will be completed: Compliance D = 05/18/2012	w ges

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI21

Facility ID: 000459

If continuation sheet

Page 9 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED					
		155567	B. WIN			04/18/	2012
	ROVIDER OR SUPPLIER	H AND REHABILITATION CENTE	:R	1400 M	ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR VAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	(X5) COMPLETION DATE
PREFIX	NFPA 101 MISCELLANEOU OTHER LSC DE Based on obserinterview, the fensure 2 of 4 pfire barrier wall by an approved for the specific capable of main resistance of the 19.1.1.3 requires facilities to be operated to min possibility of a requiring the eroccupants. LSC requires pipes, ducts, cables, where the similar building that pass through shall be protected (1) The space be penetrating item barrier shall me following condia. It shall be fill that is capable fire resistance of the space of the spa	US (FICIENCY NOT ON 2786) (vation and facility failed to benetrations of the las were protected device designed purpose and intaining the fire maintained and inimize the fire emergency vacuation of the las 8.2.3.2.4.2 conduits, bus wires, air ducts, es and ducts, and g service equipment and the fire barriers ted as follows: between the mand the fire eet one of the itions: led with a material of maintaining the of the fire barrier.	K01	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(s) se lisis ier the of of ots lee 2 be oic ed e vill	COMPLETION
	for the specific	e that is designed purpose. penetrating item			The facility Preventive Maintenance program was updated to ensure routine		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI21

Facility ID: 000459

If continuation sheet Page 10 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLI	
		155567	B. WIN			04/18/	2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
		LLAND DELIADULITATION CENTE	1400 MEDICAL PARK DR ER FORT WAYNE, IN 46825				
UNIVERS	SILY PARK HEALT	H AND REHABILITATION CENTE	K	FORTV	VAYNE, IN 46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·		IAG	inspections of the facility fire		DATE
		o penetrate the fire			barriers are completed to ensu	ire	
	·	eve shall be solidly			ongoing compliance. Findings	will	
		parrier, and the			be reported to the Executive		
	l •	the item and the			Director for review and follow up.By what date the systemic		
	sleeve shall me				changes will be completed:		
	following cond				Compliance Date = 05/18/2012	2	
		led with a material					
		of maintaining the					
		of the fire barrier.					
	b. It shall be pi	·					
	approved device that is designed						
	for the specific	• •					
	_ ·	oractice could affect					
	two of six smo	ke compartments.					
	Findings includ	de:					
	Based on an ob	oservation with the					
	Maintenance Si	upervisor on					
		:45 p.m., the main					
	hall attic fire b	arrier wall had an					
	unsealed penet	tration measuring					
	two inches aro	und electrical wires					
	and a four inch	n gap around metal					
	conduit. Meas	urements were					
	provided by the	e Maintenance					
	Supervisor. Ba	sed on an interview					
	with the Mainte	enance Supervisor					
	time of observa	ation, this wall was					
	a fire barrier w	all.					
	3.1-19(b)						
	3						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI21

Facility ID: 000459

If continuation sheet Page 11 of 11